In The Matter Of:

David Cherry, et al. v.

Macon Hospital, Inc., et al.

Hanna C. Ilia, M.D.

March 19, 2013

Vowell and Jennings, Inc.

214 Second Avenue North

Suite 207

Nashville, Tenessee 37201

VJ VOWELL AND JENNINGS

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Page 29

smoker?
A. Yes, sir.
Q. And that would be a risk factor for heart attack; would it not?
A. Absolutely.
Q. And as described, pain from neck and jaw down to midchest would be a pain pattern consistent with the presentation of a heart attack in a 58-year-old woman; would it not?
MR. JAMESON: Object to the form of the question.
You can answer.
MS. BROWN: Object to the form.
THE WITNESS: No, not necessarily.
Only -- she did not come only with chest pain. First -- first thing she came was sunburn, and you have to put that in the equation, sir. You can't have one without the other.
BY MR. KEHOE:
Q. Is sunburn listed in the triage note, Doctor?
A. Yes, sir.
Q. That's down at the -- at the bottom; is it not?
A. Yes, sir.

Page 30

Q. Is it your testimony to the ladies and gentlemen of this jury that this woman presented to the emergency room at Macon County General Hospital with ten out of ten pain for sunburn?
A. No, it was not presented like this, but the sunburn was there.
Q. She had a radiating pattern of pain; did she not?
A. I did not know that. And I -- it's not like I did not know that, but -- did not say it was radiating. Was separate pain. When I asked my own history from her, start from the jaw -- she had pain in the jaw, in the neck, and the midchest, and the back.
Q. And that is consistent -- that is consistent and worrisome for a woman presenting with a heart attack?
A. Absolutely.
Q. And she additionally had a report of having experienced nausea and vomiting, didn't she?
A. She didn't have that not in the emergency room, no.
Q. Her history that was obtained in the course of --

Page 31

A. Yes.
Q. Let me finish, Doctor, and then -- then I'll -- then I'll let -- I'll let you finish, and we'll maintain a record here.
A. Uh-huh.
Q. The history that she presented and was noted through the triage process is that she had experienced nausea and vomiting times one in the hour or so prior to reaching the emergency room?
A. She -- she did have an episode of nausea and vomiting. Yes, sir, I'm aware of that.
Q. And she was noted and described as being anxious; is that right?
A. Extremely anxious, yes, sir.
Q. And that in addition to the cholesterol and the smoking was also one of the things that you indicated might be worrisome or a risk factor?
A. Absolutely.
Q. And she was also reported as rubbing her chest, wasn't she?
A. She was, like, moving, you know, rocking back and forth, yeah.
Q. Don't they say that -- that she is rubbing her chest?
A. The nurse's note, yes.

Page 32

Q. If she's really being troubled by a sunburn, are you telling us that a person could be expected to be rubbing that sunburn then?
A. I did not see her rubbing her chest, no.
Q. So the nurses noted that and not you?
A. That's nurse's note, yes, sir.
Q. Would you agree that with all of the notations concerning this 58-year-old female with ten out of ten pain in her jaw, chest, neck, and back, nausea and vomiting times one, anxious, and rubbing her chest would be a pattern consistent with a heart attack until proven otherwise?
A. Yes --
MR. JAMESON: Object to the form.
MS. BROWN: Object.
BY MR. KEHOE:
Q. I'm sorry?
A. Is a pattern of heart attack?
Q. Isn't that -- is that indeed a pattern of a heart attack until proven otherwise?
A. They're concerning signs, absolutely, for a heart attack.
Q. And it would be incumbent upon good emergency room care to rule out that heart attack?
A. Yes, sir.

Page 49

a sudden onset; is it not?
MR. JAMESON: Object to the form of the question.
MS. BROWN: Object to the form.
THE WITNESS: No, sir.
BY MR. KEHOE:
Q. No?
A. No.
Q. So the pain was not described as sudden in onset?
A. Well, sudden onset, but the timing is -- I had different -- different impression about the timing.
Q. You did note in -- yourself that it was sudden in onset, didn't you? I mean, you circled the word sudden?
A. Yes, I remember that.
Q. And the nurses describe the onset as two to three hours earlier; did they not?
A. That's in the nurse's note, yes, sir.
Q. And those notations would be consistent with what I represented to you as Mr. Cherry's testimony that the onset of the sudden ten out of ten pain was about 5:00 p.m.?
A. I don't know if Mr. Cherry presented, but

Page 50

I know my -- my impression when I asked was she had pain longer than that.
Q. What did you note in your focused history about the onset of pain other than the circle of sudden?
A. I don't have the note. We don't write everything in the note. I mean...
Q. Would you agree that if the onset was around 5 o'clock, then the blood draw would have taken place less than three hours after the onset of the chest and back -- jaw and back pain?
A. Yes, sir.
Q. And that would make it unreliable for ruling out a heart cause; would it not?
A. If it's three hours, yes, sir, for the lab. Yes, sir.
Q. And there was also a troponin level that was done.
For the benefit of the ladies and gentlemen, the -- troponin is a very heart muscle specific enzyme, isn't it?
A. You can have positive troponin and kidney disease too, but it's very specific for the heart, yes.
Q. And the troponin was also for my blood

Page 51

draw that occurred at 1943?
A. Yes, sir.
Q. Was either the troponin level or the CK/MB band cardiac enzyme level ever repeated before she was released home?
A. No, sir.
Q. Why not?
A. Why they were not repeated?
Q. Why weren't they repeated if it was important to rule out a cardiac cause of her complaint?
A. Well, the last time when I checked on her -- I went to see her four times total that I remember. The last time I saw her -- you have to -- to remember, she was monitored all this time. Look at the monitor. The vital signs, everything was stable. She was -- she was calm.
No worrisome sign whatsoever.
Went to see -- she told me her back was hurting the most. Then I gave her Toradol. And I thought Toradol might help. After I gave her the Toradol, then went to reassess her again, and she says she's feeling better.
So the impression I had, this is musculoskeletal pain. And at that point, I said,

Page 52

Well, we have everything looking good. And I remember she was eager to go home. And I said -- So if everything is good, can I go home? I said, Sure. I mean, I -- I had -- I felt comfortable there's absolutely no cardiac event on this patient.
And I -- I thought that would be best for the patient, you know, keep them -- or transfer them somewhere.
Q. So the Toradol was given for the back tenderness that you've described?
A. Yes, sir.
Q. It was not given for sunburn then?
A. No.
Q. Would you agree that a musculoskeletal pain diagnosis would be of a much lesser clinical significance of potential severity than a heart attack?
A. Oh, absolutely.
Q. And if you want to rule out a heart cause, you would need to repeat the CK/MB bands as well as the troponin so you would have a -- a later reference point, wouldn't you?
A. Well, you have to see every patient and assess them over and over. When you see a patient

Page 53

don't -- don't respond to nitroglycerin, you monitor for over 2-1/2 hours, there's absolutely no ectopies, no PVCs or PAC or any irregular rhythm, and you see them responded to Toradol. I had -- I had -- I felt very comfortable. You talk to them. You feel they are reliable. If anything happened, they would come back. And you act -- in a small town, you know they're going to come back if any -- if anything happened. But in my mind, there's absolutely no cardiac issue there.

Q. So there was nothing of her presentation that you felt was of significant concern to warrant repeating labs?

A. At the end of the visit, no, sir.

Q. So her pain level, then, was significantly improved; is that your impression?

A. I -- I remember I asked her specifically. She said, I am better. When I asked her what was the scale on her pain, I -- I don't remember. I asked that question.

Q. You did order for her in addition to the labs nitroglycerin; did you not?

A. I did.

Q. How many administrations of nitroglycerin

Page 54

did you order, Dr. Ilia?

A. One.

Q. And how did you choose the number one as opposed to two, three, or four?

A. Well, she presented with multiple complaints. And -- and I looked at it. I want to give her nitroglycerin what we call as a diagnostic and therapeutic test. I wasn't sure it was cardiac. Since I had no relief from nitroglycerin, so probably is not.

Q. To have a trial of nitroglycerin to help rule in or rule out a heart cause, would you agree that you need repeated administrations of the nitroglycerin?

A. If you -- if you suspect heart attack, yes, you do.

Q. At the time that you ordered the nitroglycerin, there had to be a suspicion, then, of a heart attack. Am I wrong?

A. I won't say -- that was the concern, for heart attack, yes.

Q. And if there is a concern for heart attack and you're going to use nitroglycerin to try to help rule that in or out --

Page 55

A. What --

Q. -- wouldn't this -- wouldn't the appropriate protocol be for repeated administrations of it?

A. Well, then after I -- I had the EKG and I felt comfortable with the EKG, look at the vital signs, look at the sunburn corresponded to exactly what her pain was, and I -- I felt comfortable monitoring her.

Q. Well, let's look at her -- her EKG, Dr. Ilia. I believe that -- I'll give you a page number here, Doctor. I believe it's Page 10. Did you find that?

A. Yes, sir.

Q. There's a machine or a computer interpretation provided with the EKG; is there not?

A. Well, they all do, yes, sir.

Q. What are the advantages of this type of multilead EKG versus what you see on a monitoring screen?

A. Well, this is 12-lead EKG. The monitor shows you 1 lead.

Q. So it gives you much more information?

A. Yes, sir.

Page 56

Q. What was the computer EKG machine interpretation?

A. What -- do I have to read it?

Q. Well, what is it?

A. "Sinus rhythm with sinus arrhythmia. Right atrial enlargement, rightward axis, possible anterior infarct, age undetermined."

Q. And the conclusion was an abnormal electrocardiogram?

A. Yes, sir.

Q. And you had --

A. That's the computer conclusion, yes, sir.

Q. And you had that to consider forever -- whatever it was worth in conjunction with her earlier reports of chief complaints, all of the triage notes to mix in with your clinical impression?

A. In my opinion, this was a normal EKG when I looked at it, and it did not concern me, no, sir.

Q. When you had it to -- to look at, was the printout already there, the -- what you just read, the possible anterior infarct, age undetermined?

A. Usually -- yeah, all of the printout was there, yes, sir.

Page 73

A. No, sir.
Q. Or the enzymes?
A. No, sir.
As far as I remember, no one was really concerned about her condition. That's why we all were devastated when she came back the next day.
Q. Doctor, let me direct you to Exhibit No. 4.
A. Exhibit No. 4?
Q. Yes, sir.
A. What page number is that? What page? I'm sorry.
Q. It's at the end of the chart, which ends at Page 44, I think we've determined, and then the exhibits will continue after that, 2, 3, 4. And I want you to go to Exhibit No. 4.
A. Yes, sir. I found.
(Marked Exhibit No. 4A.)
BY MR. KEHOE:
Q. I'll give you a 4A, which may be a little easier to -- to use. And see if you can tell me what Exhibit No. 4 and 4A would be.
A. This is a fail safe checklist for chest pain.
Q. Is that something that you as an emergency

Page 74

room physician would have access to?
A. When I work this -- this is from EmCare who I work with. And I -- I give to all the physicians. I have it in the doctor's lounge.
Q. There's been some testimony that this is even maintained in the crash cart in the emergency room.
Have you ever seen it there?
A. In the crash cart? I am not sure. I really -- I really doubt it.
Q. Is this something that would even be a pocket carry item?
A. Yeah, it could be. Yes, sir.
Q. How many of these boxes would -- would need to be checked before it would be of significance if one has chest pain before it would be indeed worrisome for a heart cause?
MR. JAMESON: Object to the form of the question.
MS. BROWN: Objection.
THE WITNESS: We don't have --
BY MR. KEHOE:
Q. I'll repeat it for you.
How many of these check boxes would -- would have to be checked off as -- as present

Page 75

before it would be incumbent upon you to do everything reasonable to exclude a cardiac cause of the chest pain?
MR. JAMESON: Same objection.
MS. BROWN: Same objection.
BY MR. KEHOE:
Q. You can answer.
A. I don't -- I don't know if there's any number there, specific numbers they're talking about.
Q. Well, I'm asking for your assessment.
How many would you expect to be checked off before it would be of concern to you?
A. I don't have a number in mind. Any concern, you know, your duty workup.
Q. So if there's any -- any concern after you use this fail safe checklist, then you would do things like get the confirmatory redraws of cardiac enzymes and repeat EKGs?
A. These -- these are guidelines; these are not authoritative. You have still to assess the patient, still to examine them, still to monitor them. And you go to your own conclusion. I mean, that's -- that's how medicine is practiced.
Q. Well, let's -- let's look at what is

Page 76

listed under the fail safe checklist for chest pain under the History section.
If this was to be used, there would be a check mark next to "is the patient older than 50?"
Would you agree with that?
A. Yes, sir.
Q. There would be a check mark next to "does the patient have hypertension, diabetes, or high cholesterol, or smoking history?"
A. Yes, sir.
Q. And there would be a check mark there because --
A. She was a smoker.
Q. She has two of them? She has both high cholesterol and a smoking history?
MR. JAMESON: Object to the form of the question.
BY MR. KEHOE:
Q. Is that correct?
A. What's that?
Q. She has both -- she has two of the items listed in that category?
A. Well, she -- she was treated for cholesterol. Whether or not she had high cholesterol when she came in, I did not know that.

Page 77

But, yes, she does have history of hypercholesterolemia, yes.
Q. If a patient comes in and you're going to go through this chest pain checklist, you would have to assume if she's on simvastatin that it's to treat high cholesterol, wouldn't you?
A. Hyperlipidemia, hypercholesterolemia, yes, sir.
Q. And under the diagnostics, will you agree that her cardiac markers would be listed as indeterminate?
A. I don't know if indeterminate. I know her cardiac mark was negative. Beyond that -- I went with indetermined were negative when I checked the ones I checked.
Q. Well, the box would be checked if you were using this on Pamela, wouldn't it, that begins -- or the cardiac marker is positive or indeterminate?
A. Maybe, maybe not. But I would say that's okay. I mean, I...
Q. I mean, it says, "Indeterminate includes only one set of markers." She only had one blood draw, and that was less than three hours after a sudden onset.

Page 78

Am I wrong?
MR. JAMESON: Object to the form of the question.
THE WITNESS: According to the paper, yeah, as indetermined, yes, I mean, I agree with the paper. But it doesn't mean her presentation was according to this, no.
BY MR. KEHOE:
Q. It just means that her cardiac markers would be indeterminate in ruling in or ruling out a -- a heart cause, which is really what this fail safe checklist is designed for, isn't it?
MR. JAMESON: Object to the form of the question.
THE WITNESS: Yes.
BY MR. KEHOE:
Q. It indicates that any if -- if any answer is checked yes, this indicates a higher risk for ACS and to consider additional evaluation.
Do you see that?
A. Yeah, I saw that, sir.
Q. What is ACS?
A. Acute coronary syndrome.
Q. And we've just gone through, she would have had at least four if not more checked yes;

Page 79

would she not?
MR. JAMESON: Object to the form of the question.
THE WITNESS: I still go back and see, what is the presentation. You have to see the patient. These are guidelines. This is not what -- every time we -- we write about guidelines, you always say, the doctors will decide at the end, you know, what we feel are appropriate and what is in the best interest for the patient.
There's nothing here which say -- these are just information will guide you to what you feel is best for the patient. None -- none of this is authoritative.
BY MR. KEHOE:
Q. And being guided by what is best for the patient means that you would have to err on the side of patient safety?
A. Well, absolutely.
Q. And that means you would have to rule out life endangering conditions that would be included in a differential before reaching a lesser significant -- lesser critical diagnosis?
You can -- you can answer, sir.

Page 80

A. Ultimately, you're going to rely on your experience and your knowledge and what you see, and that's what you're going to make your decision, and in your -- the best to you, you can decide what is really the best for the patient.
I mean, all this book will give out the information. But ultimately, one comes to judgment, you have to put all this together and feel what is really best for the patient, and you take it from there.
Q. Was Pamela Cherry's emergency room care of the 30th the subject of a quality assurance assessment or peer review process at the hospital?
A. I'm not aware of that.
MR. JAMESON: Objection.
BY MR. KEHOE:
Q. You were not a participant in any such review; is that --
MR. JAMESON: Objection. I'm going to instruct the client not to answer that question. That is privileged under Tennessee's peer review statute.
BY MR. KEHOE:
Q. I'm just asking -- just for the record, I'm just asking you a -- a yes-or-no question.